Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RGV HEALTHCARE SYSTEM
BOX 6582
MCALLEN TX 78502

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-10-2077-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Request for Reconsideration: "DWC rules clearly states that case management is the responsibility of the treating doctor to coordinate the care of the injured worker and facilitate timely, productive, return to work. The team conference must be triggered by a change in the injured workers treatment or condition…We only review cases where lost time or change in work status has occurred."

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed the bill and attached documentation, concluded the services provided were those ordinarily performed by the treating doctor, and declined to issue payment."

Response Submitted by: Texas Mutual Insurance; 6210 E Hwy 290; Austin TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 9, 2009	99361 W1	$113.00	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 defines case management responsibilities.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 27, 2009

- CAC-W1 Workers compensation state fee schedule adjustment
- 892 Denied in accordance with DWC rules and/or medical fee guideline

Explanation of benefits dated July 13, 2009

- CAC-W4 No additional reimbursement allowed after review of appeal/reconsideration
- 891 The insurance company is reducing or denying payment after reconsideration

Issues

1. What are the billing and documentation requirements for case management services?
2. Did the requestor support its billing for case management services?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 states in pertinent part, (e) Case Management Responsibilities by the Treating Doctor is as follows: (1) Team conferences and telephone calls shall include coordination with an interdisciplinary team. (A) Team members shall not be employees of the treating doctor. (B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call. (2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.
2. The submitted report was reviewed. According to 28 Texas Administrative Code §134.204 (e) (1) and (2), the documentation does not include the name and specialty of each individual attending the team conference or engaged in a telephone conversation and there is no documentation to support a change in the condition of the injured employee. The requestor did not support its billing of CPT code 99361.
3. Therefore, the requestor is not entitled to reimbursement for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	MAY , 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.